January 20, 2005

TO: Categories 1, 2, 3, 5, 6, & 7 Continuing Education Providers

Mary Stewart
Continuing Competency Program Coordinator

PROVIDER RENEWAL APPLICATION

The providership approval period for Categories 1, 2, 3, 5, 6, & 7 Continuing Education (CE) Providers ends July 1, 2005. Should your organization wish to renew their Kentucky Board of Nursing approved CE Providership, please complete the enclosed renewal application form, attach all required documentation and submit the materials to my attention at the Board office. **The application fee for renewal of provider approval is one hundred and fifty dollars ($150.00) and must be submitted with the completed application form.** The Provider Renewal Application packet should be submitted to the Board office no later than March 31, 2005 in order to assure sufficient time for processing and review.

As a reminder, any changes in providership name, address, phone number, fax number, e-mail address, or nurse administrator must be indicated on the renewal application form. (Attached, for your information, is a label showing your provider information as it appears in our records.) If a change in nurse administrator has occurred, please include a copy of the newly appointed nurse administrator's curriculum vitae. Your assistance in keeping KBN CE provider records current is greatly appreciated.

Should you have questions about the renewal process or the information requested in the renewal application, please contact me at (800) 305-2042 or 502-329-7000, extension 237. You may also fax me at 502-696-3959.

FOR KBN USE ONLY

APPROVED THROUGH
JULY 1, 2007

Date Paid_____

Amount Paid _____ _____ _____
Reviewed By

_____
Date

KENTUCKY BOARD OF NURSING
312 WHITTINGTON PARKWAY, SUITE 300
LOUISVILLE, KY 40222-5172
(502) 329-7000

"Request for Renewal (1992)"

PROVIDER RENEWAL APPLICATION

INSTRUCTIONS: Please type or print the information requested and submit to the Kentucky Board of Nursing at the above address by March 31, 2005
An application fee of $150.00 must be submitted with the completed application form

1. PROVIDER CORE NUMBER: _____

2. PROVIDER NAME:_____

   ADDRESS: _____

   _____

   PHONE NO: _____ FAX NO._____

   E-MAIL ADDRESS: _____

3. NURSE ADMINISTRATOR:
   NAME: _____
   LICENSE NO: _____ PHONE NO. _____

4. CHIEF ADMINISTRATIVE OFFICER OF PROVIDER ORGANIZATION/AGENCY:
   NAME: _____
   TITLE: _____

5. DO YOU WISH CONTINUED PROVIDER APPROVAL? YES _____ NO _____

6. **Complete and submit** one copy of the attached "Official Record of Providership Continuing Education Activity."

7. **Complete and submit** one copy of the attached "Retrospective Self-evaluation."

In accordance with the intent of Kentucky Revised Statue 314.073 and Kentucky Administrative Regulations 201 KAR 20:200, 20:215, and 20:220, I hereby agree to comply with the specified requirements regarding the provision of mandatory continuing education activities.

_____ _____
Signature of Nurse Administrator Date

KENTUCKY BOARD OF NURSING
312 WHITTINGTON PARKWAY, SUITE 300
LOUISVILLE, KY 40222-5172

CONTINUING EDUCATION PROVIDER SELF-EVALUATION

PROVIDER NAME: _____ **CORE NO.** _____

Reporting Period: January 1, 2003 through December 31, 2004

I. STATISTICS

Using data from the Official Record of Continuing Education Providership Activity, indicate below the approximate number of offerings and the number of nurses attending for this reporting period.

Number of Offerings _____ Nurse Participants RN _____ LPN _____

II. PARTICIPANT EVALUATION SUMMARIES:

Were any items on the Participant Evaluation Summaries from this reporting period rated below average by more than 20 percent of the participants?

YES _____ NO _____

If you answered yes to the above question, please append, in chronological sequences, those Participant Evaluation Summaries. An explanation for and a resolution to correct the below average rating must be included.

III. OFFERING ANNOUNCEMENTS:

Please **attach** a copy of an offering announcement for any offering presented during this reporting period.

IV. SCHEDULE OF OFFERINGS:

Enclose one (1) copy of the proposed schedule of offerings to be presented during the next reporting period. Proposed schedule should include offerings by title and anticipated presentation date.

The Board reserves the right to request submission of copies of continuing education files from the provider.

V. SUBJECTIVE DATE

List the three (3) major strengths of the providership continuing education activities during the reporting period.

List the three (3) major weaknesses of the providership continuing education activities during the reporting period.

Based upon an analysis of the strengths and weaknesses identified, what strategies for resolution of providership challenges and problems are planned? Designate target dates.

CHALLENGES/PROBLEMS	STRATEGIES FOR RESOLUTION	TARGET DATE

OFFICIAL RECORD OF CONTINUING EDUCATION PROVIDERSHIP ACTIVITY

Provider Name: ____

INSTRUCTIONS: List the requested information by quarters for each continuing education offering. Calculate quarterly subtotals for the contact hours and attendance columns.

☐ January 1 – March 31, _________ (year)

☐ July 1 – September 30, ________ (year)

☐ April 1 – June 30, _________ (year)

☐ October 1 – December 31, ________ (year)

DATE PRESENTED	OFFERING NUMBER	OFFERING TITLE	COSPONSORED WITH	CONTACT HOURS AWARDED	ATTENDANCE			
					RN	LPN	OTHER	TOTAL

OFFICIAL RECORD OF CONTINUING EDUCATION PROVIDERSHIP ACTIVITY

Provider Name: ____

INSTRUCTIONS: List the requested information by quarters for each continuing education offering. Calculate quarterly subtotals for the contact hours and attendance columns.

- ☐ January 1 – March 31, _________ (year)
- ☐ July 1 – September 30, ________ (year)
- ☐ April 1 – June 30, _________ (year)
- ☐ October 1 – December 31, ________ (year)

DATE PRESENTED	OFFERING NUMBER	OFFERING TITLE	COSPONSORED WITH	CONTACT HOURS AWARDED	ATTENDANCE			
					RN	LPN	OTHER	TOTAL